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In The
Supreme Court of the United States

THERESA NOREN,

Petitioner,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, LINCOLN NATIONAL CORPORATION, and CARTOYS, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does an insurer's failure to comply with ERISA[1]-required notice in the Summary Plan Description of all procedures and time frames that are a prerequisite to judicial review, creating a conflict with the relevant plan provision(s), bar the insurer's non-statutory, non-jurisdictional defense that the claimant failed to exhaust administrative remedies?

---

[1] Employee Retirement Income Security Act.

LIST OF PARTIES

The parties to this action are listed in the caption: the Petitioner, Theresa Noren, was plaintiff and appellant in the courts below. Jefferson Pilot Financial Insurance Company, Lincoln National Corporation, and CarToys, Inc., were defendants and appellees.

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STATEMENT OF JURISDICTION

(i) The District Court entered its Order and Judgment March 2, 2009. The Ninth Circuit's Memorandum was filed May 10, 2010.

(ii) The Petition for Rehearing En Banc was denied June 29, 2010. The mandate was issued July 7, 2010.

(iii) The Order (by letter) granting an extension of time to file the petition for a writ of certiorari was issued September 14, 2010, and the deadline extended to October 12, 2010.

(iv) This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTES, REGULATIONS, COURT RULES INVOLVED

Title 29, United States Code, Section 1104(a)(1):

"[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries".

Title 29, United States Code, Section 1133(1) - (2):

Every employee benefit plan shall—

"(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2520.102-3:

Contents of summary plan description.

...**The summary plan description *must* accurately reflect the contents of the plans** ... The following information ***shall be included*** in the summary plan description of ... employee welfare

benefit plans ...

(j) The plan's requirements respecting eligibility for participation and for benefits.....

* * *

2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits....

* * *

(l) For ... welfare benefit plans, a statement clearly **identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction...of any benefits** that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. ... The foregoing summaries shall be disclosed in accordance with the requirements under 29 C.F.R. § 2520.102-2(b).

Title 29, Code of Federal Regulations, Section 2560-503-1(a):

"... this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits ..."

Title 29, Code of Federal Regulations, Section 2560-503-1(b)(1-3), (b)(5):

"Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing ... notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate... .

(2) A description of all claims procedures ... and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. ...

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants".

Title 29, Code of Federal Regulations, Section 2560-503-1(c)(2):

"... (2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act".

Title 29, Code of Federal Regulations, Section 2560-503-1(f):

"Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time,". ...

Title 29, Code of Federal Regulations, Section 2560-503-1(f)(3):

"Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination ..."

Title 29, Code of Federal Regulations, Section 2560-503-1 (g)(1)(iv)-(v)(a):

"Manner and content of notification of benefit determination. (1) Except as provided in paragraph

(g)(2) of this section, the plan administrator shall provide a claimant with written ... notification of any adverse benefit determination. ... The notification shall set forth, in a manner calculated to be understood by the claimant --

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

...

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(4):

"Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(2)(iii)-(iv):

"Appeal of adverse benefit determinations.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures – ...

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination".

Title 29, Code of Federal Regulations, Section 2560-503-1(i)(5):

"Timing of notification of benefit determination on review. ...

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan

administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate".

Title 29, Code of Federal Regulations, Section 2560-503-1(j)(2)-(3) and (5)(i):

"Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written ... notification of a plan's benefit determination on review. ... In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section"

(5) In the case of ... a plan providing disability benefits -- (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar

criterion will be provided free of charge to the claimant upon request";

Title 29, Code of Federal Regulations, Section 2560-503-1(*l*):

"Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(4) – (5) and (8)(iv):

"Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) ...

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) ...

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information. ...

(iv) In the case of ... a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's

diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination".

STATEMENT OF THE CASE

1. Theresa Noren participated in an ERISA plan administered by Jefferson Pilot Financial Insurance Company, through her employment with CarToys.[2] Noren became disabled in June 2005 and filed for short-term disability benefits. After administrative proceedings, Jefferson denied the claim November 3, 2006. App.34a. The denial letter stated she "may" appeal a second time. November 6, 2006, Noren asked for 180 days from receipt of the complete administrative file to appeal. App. 39a. Jefferson noted this request as a "second appeal". App.42a. In this and at least one other letter, Noren asked whether this was an ERISA plan and also for disclosure of relevant documents, including the basis ("Presley Reid Disability Advisor guidelines") for denying benefits. App.39a. These guidelines formed the basis for denial.[3]

2. Jefferson neither denied nor agreed this was an ERISA plan, and did not provide the requested and required documents. Though Jefferson had initially documented Noren's November 6, 2006 request as a second appeal, no additional material was sent in by Noren.

3. Noren brought suit in the Western District of Washington, and thereafter moved to compel in order to access materials Jefferson was required to disclose but had never provided her.

4. In reply, Jefferson for the first time asserted the affirmative defense of "prudential

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[2] On approximately April 3, 2006, Jefferson Pilot merged with Lincoln National Corporation of Pennsylvania. The merged company operates now as Lincoln Financial Group.

[3] App.32a, 36a(3-7 days disability for fibromyalgia).

exhaustion," claiming Noren failed to submit facts bringing her claim within the exceptions to exhaustion.

5. The district court concluded that the Plan required two appeals, that Jefferson had no obligation to notify Noren of the two-appeal requirement, and she did not complete a second appeal. The court dismissed with prejudice, App.7a-13a, without considering Noren's Motion to Compel materials Jefferson never provided.

6. Without oral argument, a majority of the Ninth Circuit Court of Appeals panel affirmed, in an unpublished decision dated May 10, 2010 (App.2a-5a). The majority concluded Noren failed to demonstrate any exception to the exhaustion requirement. The majority held Noren waived the argument that under 29 C.F.R. §2560.503-1(*l*), Jefferson's "unreasonable procedures" deemed the remedies to be exhausted.

7. The dissent concluded Noren had preserved the latter argument, and instead the Court should reverse and "remand for the district court to develop the record as to this claim and its application to the ERISA regulations in the first instance"—that is, a triable issue.

8. The petition for rehearing en banc was denied.

9. Initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act (ERISA), a federal law. The Ninth Circuit had jurisdiction under 28 U.S.C. § 1291.

REASONS FOR ALLOWING THE WRIT

I. PRELIMINARY STATEMENT RE CONFLICTS

The Ninth Circuit in this case decided an important question of federal law on which the circuits conflict: that is, whether a difference between the Summary Plan Description (SPD) and a provision in an ERISA plan violates ERISA's requirement that insurers notify plan participants of all time limits and exhaustion procedures, thus precluding the insurer from asserting the non-jurisdictional affirmative defense of "prudential exhaustion."

In the process of so deciding, the Ninth Circuit's decision conflicts with this Court's holding that non-statutory defenses are not jurisdictional. The rule should be when the SPD and a plan provision conflict on exhaustion of remedies, the insurer's failure to give the claimant mandated notice of the procedures and time limits for exhaustion is fatal to any exhaustion defense. This Court should grant certiorari to resolve the question.

The Ninth Circuit also ignored the critically-important and potentially-fatal result of applying prudential exhaustion to bar a claimant's right to judicial review in an ERISA benefits-denial case.

A court's unfamiliarity with ERISA minimum regulations and misuse of prudential exhaustion improperly relieves insurers of their duties to plan participants. It effectively lowers the standards that plan administrators must meet and allows them to escape their fiduciary duties. That is what happened in this case.

With few appellate cases explaining prudential exhaustion in ERISA actions, a writ of certiorari is necessary to harmonize the variety of Circuit Court holdings and to rule that:

(a) An insurer's failure to give ERISA-required notice of all procedures and time frames in the SPD bars it from asserting the non-statutory, non-jurisdictional defense that the claimant failed to exhaust administrative remedies she never knew about.

(b) Where there is a conflict between the SPD and a plan provision, the version most favorable to the claimant prevails.

II. THE COURT SHOULD ACCEPT CERTIORARI TO HARMONIZE CIRCUIT CONFLICTS OVER THE EFFECT OF ERISA-REQUIRED NOTICE AND DISCREPANCIES BETWEEN THE PLAN AND SPD.

A. Without ERISA-Required Notice, Insurers Cannot Assert Prudential Exhaustion.

The Second Circuit in *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003) harmonized these rules, but other courts have strayed from these principles and issued a chaotic variety of decisions.

Generally, where a plan provision differs from the SPD, circuit courts have conflicted over which should govern as discussed below. Some have held that the SPD controls; others say the opposite or simply ignore the SPD. Still others require detrimental reliance by, or prejudice to, the

claimant.

The specific rule, however, is that, where the insurer violates ERISA-required minimum regulations requiring it to give notice in the SPD of procedures and time frames that are a prerequisite to judicial review, 29 C.F.R. § 2560.503-1(b) (set forth below), the court is not deprived of jurisdiction, but rather, the insurer must prove it gave such notice before it can assert exhaustion as a defense.

ERISA requires that the appeals process be in the SPD to satisfy notice regulations. Minimally, the SPD must ensure claimants know ***all* claims procedures and time limits for appealing adverse benefit determinations.** 29 C.F.R. § 2560.503-1(b):[4]

> **(b) Obligation to establish and maintain reasonable claims procedures.** Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). **The claims procedures for a plan will be deemed to be reasonable *only if* –**
>
> (1) The **claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j)** of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

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[4] *See also* 29 C.F.R. § 2520.102-3(j)(2); 29 C.F.R. § 2520.102-3(l).

> **(2) A description of *all* claims procedures ... and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 C.F.R. § 2520.102-3[.][5]**

(Emphasis added.)

Judicial review is an integral part of ERISA's appeal procedure for an adverse benefit determination; therefore, the regulations require plan administrators to give adequate notice of the time limits for such review. 29 C.F.R. § 2560.503-1.[6]

Precisely as a result of the insurer's violation of the same regulation at bar, 29 C.F.R. § 2560.503-1(b), in *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003), the Second Circuit ordered judgment entered for the claimant harmed by the insurer's violation:

> ERISA requires employers to distribute SPDs describing the plan's benefits to their employees. 29 U.S.C. §1022(a) & 1024(b). The SPD must be written in a manner calculated to be understood by the average plan participant and must be sufficiently accurate and comprehensive to apprise participants and beneficiaries of their rights and obligations under the plan. *Id.* at §1022(a). Significantly, the SPD must contain the plan's eligibility requirements for benefits

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[5] Section 2520.102-3 provides at a minimum, that to ensure claimants know, the insurer must include in the SPD ***all* claims procedures** and time limits for appealing adverse benefit determinations. 29 C.F.R. § 2520.102-3(j)(2) and 29 C.F.R. §2520.102-3(l).

[6] *E.g.*, 29 C.F.R. §2560.503-1(a), (b), (f), (g)(1), (h)(4), (j); 29 U.S.C. §1133(1).

> as well as "*the circumstances which may result in disqualification, ineligibility or denial or loss of benefits.*" ***Id.*** **at § 1022(b); see also 29 C.F.R. §2520.102-3(l).**
>
> ERISA further requires that: (1) the SPD's format not mislead or fail to inform participants and beneficiaries about the plan; and (2) any limitations or restrictions of plan benefits must not be minimized, rendered obscure, or otherwise made to appear unimportant. *See* **29 C.F.R. §2520.102-2(b).** Restrictions on benefits need not be disclosed "in close conjunction with the description or summary of benefits provided that adjacent to the benefit description the page on which the restrictions are described is noted." *Id.* ("cross-referencing" requirement); *see also id.* at § 2520.102-2(a) ("the use of clear cross-references [is] usually required" in an SPD).

As should have occurred here, the Second Circuit recognized that the insurer's violation operated to bar the claimant's right to judicial review:

> Under the ERISA statute and the DOL regulations, the denial must notify the claimant of appeal procedures under the plan. *See* 29 U.S.C. §1133 & 29 C.F.R. §2560.503-1. A written notice of denial must be comprehensible and provide the claimant with the information necessary to perfect her claim, including the time limits applicable to administrative review. *Id.* A notice that fails to substantially comply with these requirements does not trigger a time bar contained within the plan. *See White v. Jacobs*

Eng'g Group Long Term Disability Benefit Plan, 896 F.2d 344, 350 (9th Cir. 1990).

Kodak's notice was inadequate for two reasons.

First, Kodak's initial denial letter does not expressly say that Mrs. Burke had ninety days to appeal. ... Based on the denial letter's exclusive reference to spousal eligibility, Mrs. Burke's focus in turning to the handbook would justifiably have been on her eligibility, not on the time limit for appeals. *See Ross v. Diversified Benefit Plans, Inc.*, 881 F.Supp. 331, 335 (N.D. Ill. 1995)(notice insufficient where denial letter "did not mention the Plan's appeal procedure or specifically refer the claimant to the Plan book for information about the appeal procedure").

...

Secondly, even if Kodak's denial letter had cross-referenced the time limitation's provision in the handbook, the language requiring appeal within ninety days is opaque:

...

The Kodak handbook's use of the word "should" is grossly uninformative. *Cf. Harris County Hosp. Dist. v. Shalala*, 863 F. Supp. 404, 410 (S.D.Tex. 1994), *aff'd*, 64 F.3d 220 (5th Cir. 1995) ("Should," in administrative manual, "is mandatory only when used as the past tense of shall. Otherwise, should is precatory.").... It is not necessary to hold that "should" can never be construed as mandatory. *See Doe v. Hampton*, 184 U.S. App. D.C. 373, 566 F.2d 265, 281 (D.C. Cir. 1977)(use of "should" rather than "shall" or

> "must" is not automatically determinative of whether regulation is mandatory or merely precatory). In this case, however, we decline to equate "should" with "shall" or "must."[7]
>
> Here, Kodak could easily have used unambiguous mandatory language. ...
>
> ... [W]e conclude that Mrs. Burke was denied the opportunity for the full and fair review contemplated by 29 U.S.C. §1133 and the DOL regulations.

Burke, at 107-09.

The Ninth Circuit has addressed the interaction of prudential exhaustion and ERISA-required notice in terms of excusing the defense of prudential exhaustion, but this is not the direct approach that courts should take. In *Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 984-85 (9th Cir. 2001), the court held that the failure to give adequate notice **excuses** a claimant from exhausting administrative remedies. In that case, the insurer at first paid benefits but after surreptitiously investigating the claimant, a claims representative called to tell Dishman she was denying his claim, later retreating to say she was "suspending" his benefits until he provided certain information. There was no policy provision or claims procedure regarding "suspension." Dishman requested a copy of the procedures. The insurer ignored the first request, and Dishman asked again. The insurer responded that it did not have a claims procedure

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[7] This is precisely the same analysis as should have been applied to the insurer's use of "may" with regard to what it later contended was a "required" second appeal. No one would understand "may" to mean "must." App.37a. Furthermore nothing prevented Jefferson from quoting the specific language in the plan to avoid any ambiguity. *Id.*

regarding suspension and termination of benefits. Though this case is substantially similar to *Dishman*, and though in the courts below, Noren argued the issues of notice and the one-appeal disclosure in the SPD, the Ninth Circuit and District Court ignored both.

The Ninth Circuit has also addressed the failure to give notice of a contractually-required arbitration procedure before the claimant could seek judicial review, which prevents the plan from arguing exhaustion. *Chappel v. Laboratory Corp. of America*, 232 F.3d 719, 726-27 (9th Cir. 2000); *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1033 (9th Cir. 2006).[8] *See also Solien v. Raytheon Long Term Disability Plan # 590*, 2008 U.S. Dist. LEXIS 43194 (D.Ariz. 2008)(applying notice requirements to contractual statute of limitations).

In *Chuck*, the court confirmed the critical nature of notice of a time bar:

> It is indisputable that the clarity and apparent finality of a benefits denial are easily affected by whether the plan discloses its justifications for the denial and by whether there has been a reasonable opportunity for full and fair review of that denial.... A] plan's compliance with §1133 serves crucial information-providing and signaling functions that lend certainty to a claimant's understanding whether a given denial is final or appealable. A plan's failure to comply with §1133, conversely, deprives claimants of a

[8] *See also LaMantia v. Voluntary Plan Administrators, Inc.*, 401 F.3d 1114, 1119-20 (9th Cir. 2005); *White v. Jacobs Eng'g Group Long Term Disability Ben. Plan*, 896 F.2d 344, 350-52 (9th Cir. 1990).

> congressionally mandated means of knowing the proper import of, and response to, a benefits denial.
>
> . . .
>
> ... [A]dequacy of notice is "important to [claimants'] to obtain full and fair reviews of their claims," and the statute and regulations "reveal a purpose to aid claimants in avoiding the obstacles a plan may place in their paths to the appeals board." ... ERISA likewise reveals a purpose of removing obstacles in claimants' paths to the courts. ... 29 U.S.C. § 1001(b). In keeping with Congress' goal of providing "ready access to the Federal courts," we must remain mindful that "ERISA is remedial legislation which should be liberally construed in favor of protecting participants in employee benefit plans."

Id. at 1033-35.

The Ninth Circuit and other circuits have not reconciled the violation of 29 C.F.R. §2560.503-1(b) with the various holdings regarding a conflict between an SPD and a policy provision, or ERISA's notice requirements generally.

B. Conflicts Between SPD and Plan.

If an SPD and a policy covered by ERISA conflict, the more favorable document controls. *Bergt v. Retirement Plan for Pilots Employed by Mark Air, Inc.*, 293 F.3d 1139, 1145 (9th Cir. 2002). The Ninth Circuit in *Bergt* joined the Second, Fifth, Sixth, Tenth, and Eleventh Circuits: *Heidgerd v. Olin Corp.*, 906 F.2d 903, 907-08 (2d Cir. 1990); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 982 (5th Cir.

1991); *Edwards v. State Farm Mut Auto. Ins. Co.*, 851 F.2d 134, 136-37 (6th Cir. 1988); *Chiles v. Ceridian*, 95 F.3d 1505, 1511 (10th Cir. 1996); *Alday v. Container Corp. of America*, 906 F.2d 660, 665-66 (11th Cir. 1990); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1570-71 (11th Cir. 1985). In reaching this holding, the *Bergt* court quoted *Hansen*:

> Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask.

Bergt, 293 F.3d at 1146 (quoting *Hansen*, 940 F.2d at 982).

The SPD, an integral part of the plan,[9] is an employee's primary source of information regarding the plan on which the employee is entitled to rely on its content. *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 110 (2d Cir. 2003). *Bergt* added: "the law should provide as strong an incentive as possible for employers to write the SPDs so that they are

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[9] *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Skinner Engine Co.*, 188 F.3d 130, 135 n.3 (3d Cir. 1999)(citing *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 949 (8th Cir. 1994); *Alday*, 906 F.2d at 665 (11th Cir. 1990)); *Bergt*, 293 F.3d at 1143); *Chiles*, 95 F.3d at 1511 & 1515 (10th Cir. 1996). *See also Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S.Ct. 865, 877 (2009).

consistent with the ERISA plan master documents, a relatively simple task." *Bergt,* 293 F.3d at 1145-46.

Bergt applied the well-established rule that an ambiguity between terms of a contract (the SPD and the plan), must be construed against the drafter. *Id.* at 1143, 1146. *See also, e.g., Banuelos v. Constr. Laborers' Trust Funds*, 382 F.3d 897, 904 (9th Cir. 2004)("Courts will generally bind ERISA defendants to the more employee **favorable of two documents -- even if one is erroneous**"); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1321 (9th Cir. 1995)(pre-*Bergt;* where an SPD fails to explain circumstances that can lead to a denial of benefits, "and differs materially from the terms of the plan, the SPD is controlling"), *overruled on other grounds by Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (2006); *Arnold v. Arrow Transp. Co.*, 926 F.2d 782, 785 n.3 (9th Cir. 1991)(an SPD can expand benefits beyond those in a master plan document).[10]

The circuits split over whether a conflict exists when an SPD is silent about a matter addressed in the policy. The Second Circuit in *Burke* held that silence in an SPD regarding an issue described in a related insurance policy creates a conflict between the two documents. *Burke,* 336 F.3d at 111 (SPD omitted affidavit requirement listed in policy, so SPD controlled). Here, the SPD's silence regarding two appeals creates a conflict with the plan.

Other circuits have held no conflict exists. *See, e.g., Koons v. Aventis Pharms., Inc.*, 367 F.3d 768,

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[10] *E.g.*, in *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the SPD stated all denial letters would detail the review requirements. Unlike here, they did. Consistent with ERISA, the claimant had notice of time limits and provisions requiring exhausting administrative remedies.

775 (8th Cir. 2004); *Mers v. Marriott Int'l Group Acc. Death and Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998). The Ninth Circuit has not addressed the issue of silence in an SPD.

Here, the Ninth Circuit overlooked the law and this Court's directives. The SPD describes only one appeal, not the plan's a two-appeal requirement. *Compare* App.25a-26a (SPD--one appeal) *with* App.27a (Plan--two appeals); App.28a-29a ("Review Procedure"--nothing about two appeals; "Claims Subject to ERISA" requires two appeals **if** the plan is an ERISA plan).[11] The denial letter (Dec. 12, 2005), App.32a-33a, only vaguely mentions "the policy" and "terms of the contract", "policy language" and "ERISA regulations" as guiding the insurer's handling of each "unique" claim.

Whether this is construed as a conflict or silence on the exhaustion defense, the insurer's omission of the procedures and time frames that it says Noren failed to exhaust was fatal to its defense. What the insurer labeled as jurisdictional was never that. It was the insurer's obligation to give notice to the claimant before she could conceivably fail to exhaust undisclosed procedures.

Courts ignore this Court's clarification that a non-statutory defense is not jurisdictional, but instead an affirmative defense. The Second Circuit rule is correct: when an SPD is silent on a matter that affects a claimant's right to judicial review, but conflicts with the related policy, the plan has failed

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[11] The insurer never told Noren her plan was an ERISA plan, despite repeated requests from her lawyer. App.30a-31a (Nov. 15, 2005); App.39a-41a (Nov. 6, 2006).

to comply with ERISA's notice mandate of critical procedures and time limits.

The circuits also split over whether detrimental reliance or prejudice is required in deficient SPD cases. The Second Circuit requires prejudice:

> The consequences of an inaccurate SPD must be placed on the employer. The individual employee is powerless to affect the drafting and less equipped to absorb the financial hardship of the employer's errors. ... The employer, however, receives a substantial benefit in return: a defense against certain state law claims....*see also* 29 U.S.C. §1144(a) (ERISA provisions "supersede any and all State laws insofar as they may . . . relate to any employee benefit plan")....
>
> ...[W]e require, for a showing of prejudice, that a plan participant or beneficiary was likely to have been harmed as a result of a deficient SPD. ...

Burke, 336 F.3d at 113.

The Third, Seventh and Eleventh Circuits require detrimental reliance. *See Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 n.8 (3rd Cir. 1991); *Andersen v. Chrysler Corp.*, 99 F.3d 846, 859 (7th Cir. 1996); *Branch v. G. Bernd Co.*, 955 F.2d 1574, 1578-79 (11th Cir. 1992). They generally require that claimant read the SPD and but for the inaccurate description would have acted differently. *See, e.g., Collins v. Am. Cast Iron Pipe Co.*, 105 F.3d 1368, 1371 (11th Cir. 1997).

The First, Fourth, Eighth and Tenth Circuits allow recovery upon a showing of either reliance or prejudice. *See Govoni v. Bricklayers, Masons &*

Plasterers Int'l. Union of Am., Local No. 5 Pension Fund, 732 F.2d 250, 252 (1st Cir. 1984); *Aiken v. Policy Mgmt. Sys. Corp.*, 13 F.3d 138, 141-42 (4th Cir. 1993)(per curiam); *Palmisano v. Allina Health Sys., Inc.*, 190 F.3d 881, 887-88 (8th Cir. 1999); *Chiles*, 95 F.3d at 1519.

The Fifth and Sixth Circuits in dicta would require neither reliance nor prejudice. *See Hansen*, 940 F.2d at 983; *Edwards*, 851 F.2d at 137.

The Ninth Circuit has not addressed the issue.

The circuits' confusion[12] demands this Court's

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[12] As one trial judge cynically described the courts' handling of ERISA cases:

> This court knows from experience that, under ERISA, trial courts, despite never having seen a live witness, routinely make, or purport to make, credibility determinations to resolve disputes between irreconcilable unsworn written testimony. It would, of course, constitute a *Rule 11* violation for an ERISA beneficiary to file an action seeking to recover benefits without having any evidentiary support whatsoever for his claim. On the other hand, a plan administrator can always be counted on to say that it relied, in reaching its decision, upon evidence that predictably contradicts the evidence offered by the beneficiary. Otherwise, there would be no dispute, and no federal court involvement. *Rule 56* simply does not fit an ERISA case. This is why the parties in the above-entitled case appropriately adopt the innovative "motion for judgment as a matter of law", arrived at by adapting procedures from administrative law. Even Dr. Watson, without Sherlock's help, could deduce from this procedural dilemma either that a new procedural rule should be created for ERISA cases, or that ERISA should be applied as it was written by Congress.

Blankenship v. Metropolitan Life Ins. Co., 686 F.Supp.2d 1227, 1232-33 (N.D.Alabama 2009).

acceptance of certiorari because ERISA requires all procedures and time frames to be in the SPD; the insurer's violation of notice requirements, or any silence or conflict on the matter, precludes it from asserting prudential exhaustion as an affirmative or jurisdictional defense.

Whether detrimental reliance or prejudice is required, Noren's lost right to seek judicial review severely prejudiced her. Had the insurer identified the ERISA plan, Noren still had the right to rely on the SPD's description of only one review.

Certiorari is needed to enunciate that prudential exhaustion cannot be asserted if an insurer failed to unambiguously notify a claimant of its administrative review procedures which bar the right to judicial review in a manner calculated to be easily understood.[13] As addressed below, failure to notify the claimant of internal review procedures is an unreasonable procedure, which deems the administrative remedies to be exhausted. 29 C.F.R. §2560.503-1(*l*).

Any other holding would relieve insurers of the duty to notify a plan participant of the time limits and requirements necessary for filing an action and obtaining court review. Insurers could avoid their duty under ERISA by omitting appeal or exhaustion requirements in their SPD. This Court cannot approve this practice.

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[13] *See, e.g., Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008); 29 U.SC. 1104.

III. THE NOREN DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT NON-STATUTORY DEFENSES ARE NOT JURISDICTIONAL.

A. The Ninth Circuit Ignored, And This Court Should Settle, The Rule That Prudential Exhaustion Is A Non-Jurisdictional Affirmative Defense.

By allowing the insurer to assert the non-jurisdictional defense of prudential exhaustion in Reply, and then misapplying that defense as depriving the court of jurisdiction, the Ninth Circuit entered a decision in conflict with this Court's holding in *Bowles v. Russell*, 551 U.S. 205 (2007); *Arbaugh v. Y&H Corp.*, 546 U.S. 500 (2006); *Eberhart v. United States*, 546 U.S. 12 (2005)(per curiam); and *Kontrick v. Ryan*, 540 U.S. 443 (2004).

In *Bowles*, the Court clarified that non-statutory claim-processing rules are not properly labeled "jurisdictional." True "jurisdictional" limitations are set by the Constitution and by Congress, not by rules of procedure or judge-made doctrine. *See Kontrick*, 540 U.S. at 452 ("Only Congress may determine a lower federal court's subject-matter jurisdiction."); *see also Bowles*, 127 S. Ct. at 2364-65 & n.3 (same). Non-statutory rules, "even if unalterable on a party's application, can nonetheless be forfeited if the party asserting the rule waits too long to raise the point." *See Kontrick*, 540 U.S. at 456.

Bowles held that its own past decisions had sometimes mislabeled non-statutory rules as

"jurisdictional." The Court described these casual invocations of the term as "drive-by jurisdictional rulings that should be accorded no precedential effect on the question whether the federal court had authority to adjudicate the claim in suit." *Arbaugh*, 126 S. Ct. at 1242-43 (quotation marks omitted).

The Ninth Circuit here violated this rule by accepting prudential exhaustion (raised only in Reply, no less) as a jurisdictional argument justifying dismissal. This is despite the fact that the Ninth Circuit has followed *Bowles:*

> *Bowles v. Russell*, 551 U.S. 205 ... (2007), clarified that court-promulgated rules are not jurisdictional.... Because *Bowles* supercedes our prior decisions, we must clarify that the exhaustion requirement set forth in *Amato* is not a jurisdictional requirement. *See Miller v. Gammie*, 335 F.3d 889, 893 (9th Cir. 2003) (en banc).

Vaught v. Healthcare Corp. Health Plan, 546 F.3d 620, 627 (9th Cir. 2008).

> [A]s a judicially-crafted doctrine, exhaustion places no limits on a court's adjudicatory power.... Unlike a rigid jurisdictional rule, prudential exhaustion provides flexible exceptions for "waiver, estoppel, tolling or futility." ... **In addition to being judge-made, the doctrine's futility exception involves a discretionary balancing of interests. Judicial prudence, not power, governs its application in a given case.**

Metro. Life Ins. Co. v. Price, 501 F.3d 271, 279 (3d Cir. 2007)(emphasis added). *See also Pease v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 445

(2d Cir. 2006); *Chailland v. Brown & Root, Inc.*, 45 F.3d 947, 950 n.6 (5th Cir. 1995).

B. The Court Should Guide Lower Courts Regarding *Bowles'* Distinction Between A Jurisdictional Bar And A Non-statutory Affirmative Defense, So That Exceptions To Prudential Exhaustion Are Accurate And Consistent.

1. Exceptions To Prudential Exhaustion.

Although, violation of the requirement to provide notice of all procedures and time frames in the SPD prevents prudential exhaustion, exceptions also overcome the affirmative defense. Exhaustion may provide an affirmative defense unless exhaustion was futile, or the plan's procedures were unreasonable (now codified in a regulation, 29 C.F.R. § 2560-503.1(*l*)), or the remedy was inadequate.

Here, because Jefferson moved to dismiss on jurisdictional grounds, raising "prudential exhaustion" as a new argument in their Reply, the courts perceived the **non-statutory** exhaustion defense as jurisdictional. Taking exhaustion as a jurisdictional bar reduced the courts' belief in its authority to excuse any failure to exhaust administrative remedies.

Naturally, courts hesitate to excuse noncompliance with a **statutory** exhaustion requirement, which **is jurisdictional.** Consequently, the circuits differ over the courts' power to excuse such noncompliance:

> While there is conflicting legal authority on this point, this Court concludes

> that it does have the power to excuse noncompliance with the exhaustion requirement of 7 U.S.C. §6912. *See Bowen v. City of New York*, 476 U.S. 467, 482-83, 106 S.Ct. 2022, 90 L.Ed. 2d 462 (1986); *Dawson Farms, LLC v. Farm Serv. Agency*, 504 F.3d 592, 597 (5th Cir. 2007); *Ace Prop. & Cas. Ins. Co. v. Fed. Crop. Ins. Corp.*, 440 F.3d 992, 1000 (8th Cir. 2006); *McBride Cotton & Cattle Corp. v. Veneman*, 290 F.3d 973, 980 (9th Cir. 2002); ***Dishman v. UNUM Life Ins. Co. of America*, 269 F.3d 974, 984-85 (9th Cir. 2001);** *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522, 530-31 (7th Cir. 1993); *The Lands Council v. Vaught*, 198 F.Supp.2d 1211, 1241 (E.D. Wash. 2002). ***But see*** *Bastek v. Fed. Crop Ins. Corp.*, 145 F.3d 90, 94-95 (2nd Cir. 1998).

Sierra Club v. United States Forest Serv., 535 F.Supp.2d 1268, 1311 (N.D.Ga. 2008)(emphasis added; citing *Dishman*, which involves non-jurisdictional prudential exhaustion).

But courts can easily excuse non-compliance with the judicially-created, nonstatutory defense, prudential exhaustion. The Third Circuit stated in *Metropolitan Life Insurance Co. v. Price*, 501 F.3d 271, 279 (3rd Cir. 2007), "In addition to being judge-made, the doctrine's futility exception involves a discretionary balancing of interests. Judicial prudence, not power, governs its application in a given case."

Courts have only infrequently told a claimant what would be sufficient to satisfy those exceptions. As discussed above, in *Dishman*, 269 F.3d at 984-85, the court excused the claimant from exhausting his

administrative remedies because, as here, the plan "gave him inadequate notice of both the denial of his claim and the available appeals procedure." *Id.* at 984.

In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Ninth Circuit concluded that the record showed the claimant **did** exhaust the administrative remedies. Therefore, *Vaught* did not reach the question whether the claimant demonstrated an exception. *Id.* at 629.

The majority here never actually considered whether, or explained why or why not, Noren exhausted her administrative remedies, but proceeded directly to the exceptions. The record showed Noren exhausted her remedies and satisfied the exceptions for futility and unreasonable procedures.[14]

2. Deemed Exhausted Regulation.

Under ERISA's "deemed exhausted" regulation, 29 C.F.R. § 2560.503-1(*l*)(2002), the failure to notify and other violations constitute an unreasonable claims procedure, violation of which deems the appeal procedures to be exhausted. The

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[14] Unlike in *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the denial letter here lacks notice of: (1) review requirements (stating Noren "may" appeal "if" she had an ERISA plan) and (2) the critical consequence of losing the statutory right to seek judicial review without a second appeal. Viewing the evidence and inferences in Noren's favor, she filed two appeals. This includes the insurer's own worksheet recognizing the "second appeal." App.42a. Viewing that against the insurer and in Noren's favor required denial of summary judgment as to exhaustion, a question ambiguous even to the insurer.

Court should breathe life into this relatively new regulation, which is intended to remedy insurer's practically routine flaunting of ERISA.

The "deemed exhausted" exception to prudential exhaustion, 29 C.F.R. §2560.503-1(*l*), has been addressed primarily by district courts, and rarely by appellate courts. Most recently, the Fifth Circuit applied § 2560-503.1(*l*) to hold although the claimant had not exhausted his remedies, the insurer's failure to notify him it had denied his claim allowed the court to deem the remedies exhausted:

> [W]hen the administrator fails to "follow claims procedures consistent with the [regulatory] requirements," including providing adequate notice that it has denied the claim, "a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any remedies under section 502(a) of [ERISA] on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." *See* 29 C.F.R. §2560.503-1(*l*).

Baptist Mem. Hosp. - Desoto, Inc. v. Crain Auto., Inc., 2010 U.S. App. LEXIS 17518, at *10 (5th Cir. Aug. 19, 2010). Certainly, where the insurer has blatantly omitted an exhaustion provision (the two-appeal provision) in the SPD, it has by definition followed unreasonable procedures and violated the minimum requirement in § 2560.503-1(b)(2), meaning the claimant is deemed to have exhausted her remedies.

In *Kegel v. Brown & Williamson Tobacco Corp.*, 2009 U.S. Dist. LEXIS 88783 (D. Nev. 2009),

the plan violated § 2560.503-1(g) when the denial letter failed to provide the specific plan provision, review procedures, and time limits. Under § 2560.503(1)(*l*) the claimant's remedies were deemed exhausted.

In *Asgaard v. Pension Comm.*, 2006 U.S. Dist. LEXIS 74679 (W.D.Mich. 2006), the defendants, claiming they had "tolled" ERISA deadlines, never provided plaintiffs with relevant documents they requested. The court rejected the exhaustion defense:

> ERISA regulations make clear that claimants are entitled to such documents. 29 C.F.R. §2560.503-1(h)(2)(iii). ...Taken to its extreme, the defendants' argument would allow an ERISA plan administrator to avoid judicial review indefinitely by merely refusing to supply requested documents or refusing to decide a claim on review. This does not comport with the requirement of a 'full and fair review' of claim determinations under ERISA. 29 U.S.C. §1133.... [D]efendants have failed to abide by the specific review timelines provided in 29 C.F.R. §2560.503-1(i).

Id. at 20-21, 25.[15]

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[15] *See also, e.g., Brogan v. Hartford Life Ins. Co.*, 2009 U.S. Dist. LEXIS 85101, 12-13 (S.D.Ohio 2009); *Linder v. BYK Chemie USA, Inc.*, 313 F.Supp. 2d 88 (D.Conn. 2004) (regulation "is unequivocal that any failure to adhere to a proper claims procedure is sufficient to deem administrative remedies exhausted"); *Fleming v. Kemper Nat'l Servs.*, 2004 U.S. Dist. LEXIS 28381 (N.D.Cal. 2004) (denying summary judgment); *Urso v. Prudential Ins. Co. of Am.*, 2004 U.S. Dist. LEXIS 23930, 2004 WL 3355265 (D.N.H. 2004)(same; violation of 29 C.F.R. §2560.503-1(i)); *Urso v. Prudential Ins. Co. of Am.*, 2004 DNH 167 (D.N.H. 2004)("The court is not

The Ninth Circuit and the Second Circuit have recognized, but not applied 29 CFR § 2560.503-1(*l*) to deem remedies exhausted as a result of a plan's unreasonable procedures. In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Court recognized 29 CFR § 2560.503-1(*l*) as an exception to exhaustion, but did not rule on that basis because the claimant had exhausted his remedies. The Second Circuit, in *Eastman Kodak Co. v. STWB, Inc.*, 452 F.3d 215, 223 (2d Cir. 2006), cited 29 CFR § 2560.503-1(*l*) to reject the exhaustion defense when the asserted review procedure came into effect **after** the lawsuit. Certiorari is justified here to provide guidance as to 29 CFR § 2560.503-1(*l*)'s effect.[16]

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persuaded that any policy favoring exhaustion would override the operation of the regulatory framework in this case"); *Barboza v. Cal. Ass'n of Prof'l Firefighters*, 2009 U.S. Dist. LEXIS 52848 (E.D.Cal. 2009)(503-1(*l*) not available under the facts); *Tindell v. Tree of Life, Inc.*, 672 F. Supp.2d 1300, 1312 (M.D. Fla. 2009)(same).

[16] The record demonstrates unreasonable procedures by, *inter alia*, inadequate notice in that Jefferson did not: (1) tell Noren she had an ERISA plan, triggering a two-appeal requirement, despite her requests for clarification; (2) disclose policy provisions regarding review in any denial letter; (3) resolve the conflict created by the SPD, providing for one appeal; (4) clarify she **must** (instead stating she "**may**") appeal a second time; (5) notify her that failure to appeal twice would foreclose judicial review. The insurer violated 29 C.F.R. §2560.503-1(f), (g)(1)(iv)-(v), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (*l*), (m)(8); 29 U.S.C. §1133(1). *See also* Dissent. App.6a.

3. Futility.

This Court should clarify the courts' authority to enforce the futility exception. Here, the insurer's unreasonable procedures made it futile for Noren to proceed any further after denial of the one review she believed the plan required.[17] Noren raised factual questions by showing that since the insurer did not, despite her repeated requests, provide her with the guidelines they relied on to deny her benefits, or what additional information they desired, another appeal would be fruitless. *See*

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[17] The majority and dissent differed as to whether Noren had waived the claim that the insurer's violations of ERISA regulations excused her from exhaustion. App.2a-6a. As the dissent concluded, Noren cited violations of 29 C.F.R. § 2560.503-1(g)(1)(v)(A), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (l), (m)(8), and then stated: "Jefferson Pilot's procedural failures have prevented claimant from understanding what the failures were in Plaintiff's claim. Without knowing the shortcomings of the material submitted on appeal, it was useless to submit anything further, if indeed there was even anything further to submit. Noren has therefore preserved her claim that Jefferson Pilot's ERISA violations prevented her administrative exhaustion." In *Vaught v. Healthcare Corp. Health Plan*, 546 F.3d 620, 627 (9th Cir. 2008), the Court held that waiver does not apply in ERISA actions: "No ERISA statute precludes courts from hearing objections not previously raised to the Plan, nor does any ERISA statute or regulation require claimants to identify all issues they wish to have considered on appeal. ... [I]ssue exhaustion is not applicable in the ERISA context." *Id.* at 630-31. The claimant's "decision to raise a new issue before the district court did not retroactively erase his prior effective exhaustion of administrative remedies." *Id.* at 633. In *Eastman Kodak*, the Second Circuit rejected the waiver argument because "appeals courts may entertain additional support that a party provides for a proposition presented below." *Id.* at 221.

Parlanti v. MGM Mirage, 2007 U.S. Dist. LEXIS 20003, at *14-15 (D. Nev. 2007)(claimant alleged, beyond bare assertions, that defendants said there was no way to exhaust remedies and his only recourse was to sue).

The Ninth Circuit ignored futility for Noren to submit further information or a second appeal because the insurer never provided Noren with the linchpin of their denial--the Presley Reid Disability Adviser disability guidelines.App.32a-39a.

4. The Burden Is On the Insurer, Not The Claimant, To Prove The Exhaustion Defense.

Because prudential exhaustion is an affirmative defense, the burden is on the insurer to demonstrate that the claimant failed to exhaust her administrative remedies under the plan. *Metropolitan Life Insurance Co. v. Price*, 501 F.3d 280 (3rd Cir. 2007)("non-jurisdictional affirmative defense"; **insurer** failed to exhaust remedies); *Karpiel v. Ogg, Cordes, Murpy, & Ignelzi, LLP*, 297 Fed. Appx. 192, 194 (3d Cir. 2008); *Pease v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435, 445 (2d Cir. 2006). The Ninth Circuit reversed the true burden of proof from the insurer to the claimant. The *Noren* decision requires the claimant to prove she exhausted her administrative remedies in order to invoke the court's subject matter jurisdiction, when under the law, the insurer must show they clearly notified the claimant of the review procedures and the effect of not exhausting them.

The decision improperly views the law and the facts in favor of the insurer and against the claimant.

IV. THE *NOREN* DECISION CONFLICTS WITH THIS COURT'S HOLDING THAT ERISA IMPOSES ON INSURERS A HIGHER-THAN-MARKETPLACE FIDUCIARY DUTY TOWARD PLAN PARTICIPANTS.

Allowing courts to apply prudential exhaustion as a jurisdictional bar clashes directly with this Court's emphatic enforcement in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), of ERISA's higher-than-market fiduciary duty owed by insurers toward plan participants. This case presents the opportunity for this Court to harmonize judge-made prudential exhaustion with ERISA's stringent high standard of fiduciary duty and thorough minimum requirements.

Glenn requires insurers to:

(a) Adhere to "higher-than-marketplace quality standards";

(b) Meet a "special standard of care ..., namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1)";

(c) Comply with the important ERISA minimum standards for "accurate claims processing by insisting that administrators 'provide a "full and fair review" of claim denials,' " ... (quoting § 1133(2));"

(d) Follow ERISA's mandate to supplement "marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B)." *Id.*, 128 S. Ct. at 2350. *See also* 29 C.F.R.§2560-503.1(a) (minimum procedural

standards including explicit procedures for giving notice, reporting, and claims processing); 29 U.S.C. § 1021(a)(disclosure to all plan participants); 29 U.S.C. § 1021(b)(reporting requirements); *id.* 29 U.S.C. § 1133 (claims procedures); 29 C.F.R. § 2560.503-1 (implementing the code).

Congressional policy in ERISA to "protect ... the interests of participants in employee benefit plans and their beneficiaries", 29 U.S.C. §1001(b), trumps any "policy"[18] behind prudential exhaustion. Contrary to *Glenn* and ERISA's explicit language, the majority's application of the exhaustion defense seriously prejudices participants. It allows insurers to avoid providing clear notice in denial letters, the only place where such notice has any real force. It permits insurers to conceal and confuse review procedures, as they did here, and then blame claimants for failing to take steps that the insurer did not clearly and adequately disclose to them.

This Court recently stated that "ERISA 'induc[es] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred'". *Conkright v. Frommert,* 130 S. Ct. 1640, 176 L. Ed. 2d 469, 478 (2010).

This Court should grant certiorari to establish a uniform rule as outlined in this petition.

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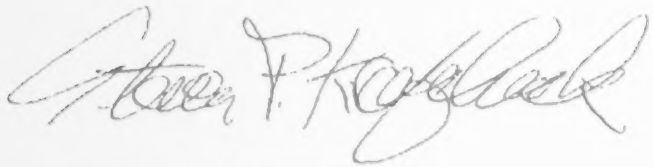
[18] *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980), *overruled in part in Bowles v. Russell*, 551 U.S. 205 (2007).

V. CONCLUSION

Without a comprehensive decision from this Court on prudential exhaustion in ERISA cases and the effect of inadequate notice or unreasonable claims procedures to bar judicial review, insurers will continue to violate ERISA law and regulations, flaunt their fiduciary duties, and preclude participants from their rightful benefits or at least their day in court.

The lower courts have failed to synthesize *Glenn* with the ERISA statutes and minimum regulations or issue uniform decisions. Allowing prudential exhaustion, contrary to ERISA requirements, to deprive courts of jurisdiction reduces ERISA's promises to hollow words.

Respectfully submitted,



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Supreme Court, U.S.
FILED
OCT 12 2010
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10-498

No. _____

In The
Supreme Court of the United States

THERESA NOREN,

Petitioner

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

THERESA NOREN, Plaintiff-Appellant,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, formerly a Nebraska Corporation; et al., Defendants-Appellees.

No. 09-35242

ORDER

June 29, 2010, Filed

Before: GOODWIN, HAWKINS and N.R. SMITH, Circuit Judges.

Judge N.R. Smith has voted to deny the petition for rehearing en banc, and Judges Goodwin and Hawkins have so recommended.

The full court was advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed.R.App.P. 35.

The petition rehearing en banc is DENIED.

NOT FOR PUBLICATION

UNITED STATES COURT
OF APPEALS FOR THE
NINTH CIRCUIT

THERESA NOREN,
Plaintiff-Appellant,

v.

JEFFERSON PILOT
FINANCIAL INSURANCE
COMPANY, formerly a
Nebraska Corporation; et
al., Defendants-Appellees.

No. 09-35242

MEMORANDUM*

May 10, 2010, Filed

Appeal from the United States District Court
For the Western District of Washington
Richard A. Jones, District Judge, Presiding

Submitted April 7, 2010**
Seattle, Washington

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R. App. P. 34 (a)(2).

Before: GOODWIN, HAWKINS and N.R. SMITH, Circuit Judges.

The district court correctly applied the prudential exhaustion doctrine in granting Jefferson Pilot's motion for summary judgment. The facts of this case are familiar to the parties and we need not recite them here.

ERISA does not explicitly require a participant to exhaust available internal review before bringing a claim in federal court. *See* 29 U.S.C. § 1132; *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 625-26 (9th Cir. 2008). However, we "long ago concluded that 'federal courts have authority to enforce the exhaustion requirement in suits under ERISA, and that as a matter of sound public policy they should usually do so.'" *Vaught*, 546 F.3d at 626 (quoting *Amato v. Bernard*, 618 F.2d 559, 568 (9th Cir. 1980)). It is undisputed that 1) the plans in this case required two levels of internal administrative review and 2) Noren failed to file a second appeal. Thus, absent an applicable exception, Jefferson Pilot's motion for summary judgment was properly granted under the prudential exhaustion doctrine.

There are three exceptions to the prudential exhaustion doctrine: 1) futility; 2) inadequate remedy; and 3) unreasonable procedures. *See Vaught*, 546 F.3d at 626–27. None of these exceptions help Noren's case.

Noren argues that, once her first appeal was rejected, 1) she did not know what further

information she could submit to influence Jefferson and 2) a second appeal would thus have been futile. The claimant's bare assertion that she does not think her appeal will be successful does not demonstrate futility. *See Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1485 (9th Cir. 1995) (rejecting a nearly identical argument).

Likewise, bare assertions are insufficient to establish the applicability of the inadequate remedy exception. Rather, this exception applies when the procedure is demonstrably inadequate or tainted by personal bias. *See Amato*, 618 F.2d at 569. Noren's only specific argument relating to inadequate procedure is that, because the letter denying her appeal did not specifically state a second appeal was required, the procedures for appeal were too vague and therefore inadequate. This argument is without merit. The appeal procedure was fully contained in the plan information, and no ERISA regulation requires that the appeals process also be outlined in denial letters. *See Diaz*, 50 F.3d at 1484-85 (rejecting an argument that a denial letter in English, which the claimant could not understand, was inadequate when the claimant had a full copy of the applicable plan in Spanish).

We have also recognized that, under 29 C.F.R. § 2560.503-1(*l*), if a plan fails to provide reasonable claims procedures, the claimant will be deemed to have exhausted her required administrative appeals. Under this theory, Noren alleges Jefferson violated ERISA requirements in a number of areas and, therefore, did not provide or

follow reasonable procedures. We need not determine if these violations amount to unreasonable procedures. Noren may have raised some of these violations before the district court, but she did not argue that the alleged violations excused her from exhausting her administrative remedies under 29 C.F.R. § 2560.503-1(*l*). As it is presented for the first time on appeal, this argument is waived. *See Singleton v. Wulff*, 428 U.S. 106, 120 (1976).

Accordingly, we AFFIRM the district court.

Noren v. Jefferson Pilot Financial Insurance Company, No. 09-35242

HAWKINS, Circuit Judge, dissenting:

The majority holds that although Noren raised possible ERISA violations below, she did not raise the arguments explicitly as an excuse for exhausting her administrative remedies. Noren's response to Jefferson Pilot's motion for summary judgment described Jefferson's alleged violations of ERISA procedures, *see* 29 C.F.R. § 2560.503-1(g)(1)(v)(A), (h)(2)(iii)-(iv), (i)(5), (j)(5)(i), (*l*), (m)(8), and then stated as follows:

> Jefferson Pilot's procedural failures have prevented claimant from understanding what the failures were in Plaintiff's claim. Without knowing the shortcomings of the material submitted on appeal, it was useless to submit anything further, if indeed there was even anything further to submit.

Noren has therefore preserved her claim that Jefferson Pilot's ERISA violations prevented her administrative exhaustion. *See In re E.R. Fegert, Inc.*, 887 F.2d 955, 957 (9th Cir. 1989). Since the entirety of the district court's analysis of whether Noren was excused from exhaustion was to note that she was not "excused from doing so," I would remand for the district court to develop the record as to this claim and its application to the ERISA regulations in the first instance.

UNITED STATES DISTRICT COURT WESTERN DISTRICT OF WASHINGTON AT SEATTLE

THERESA NOREN, Plaintiff,

v.

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY, et al., Defendants.

No. C09-0034RAJ

ORDER

March 2, 2009, Filed

I. INTRODUCTION

This matter comes before the court on Defendants' motion for summary judgment (Dkt. # 18). The court has considered the parties' briefing and supporting evidence, and has heard from the parties at oral argument. For the reasons explained below, the court GRANTS Defendants' motion.

II. BACKGROUND

Plaintiff Theresa Noren was formerly employed by Defendant Cartoys, Inc. ("Cartoys"). As a Cartoys employee, Noren was covered by Cartoys' group short-term and long-term disability insurance policies purchased for the benefit of its employees.

In June 2005, Noren filed a short-term disability claim with Defendant Jefferson Pilot Financial Insurance Company ("Jefferson Pilot") due to cervical disc degeneration and fibromyalgia. Jefferson Pilot denied the claim.

Noren's employment was terminated in August 2005. In August 2006, Noren appealed Jefferson Pilot's claim denial. In November 2006, Jefferson Pilot affirmed its denial of Noren's claim. *See* Haushild Decl. (Dkt. # 17), Ex. 10. The denial letter stated:

> As a reminder, you have exhausted your first level of appeal. If you disagree with this decision you may pursue your second and final level of appeal to the Jefferson Pilot Appeals Council. Please be sure to include with your letter of appeal addressed to the Jefferson Pilot Appeals Council, all medical records from your attending or other physicians that you would like to have considered for review.
>
> You or your authorized representative may request a review of your denied claim. Such request must be made in writing and

> submitted to us at the address below within 180 days after you receive this denial notice.
> . . .
>
> Please include your reason(s) for appealing and provide any proof documentation, such as office notes, laboratory results, x-rays and any other testing results to support your appeal. We will then provide you with a full written explanation of the decision within 45 days of receipt of your appeal.

Haushild Decl., Ex. 10. In response to that denial, Noren requested various documents from Jefferson Pilot, and requested 180 days from the date of receipt of those documents to submit additional information in support of her claim. *See id.*, Ex. 11. Jefferson Pilot sent some documents to Noren in December 2006. *See id.*, Ex. 12. Noren never requested a second appeal.

Noren filed this lawsuit in January 2008, and Defendants have now moved for summary judgment.

III. ANALYSIS

A. Standard of Review on Summary Judgment.

Summary judgment is appropriate if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477

U.S. 317, 323 (1986). Once the moving party meets that initial burden, the opposing party must then set forth specific facts showing that there is a genuine issue of fact for trial in order to defeat the motion. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986).

B. The Defendants are Entitled to Judgment as a Matter of Law Due to Plaintiff's Failure to Exhaust her Administrative Remedies.

This is an action to recover benefits under group short-term and long-term disability insurance policies under the Employee Retirement Income Security Act of 1974 ("ERISA"). Both the short-term and long-term policy plans at issue in this case include the following provision:

> **Claims subject to ERISA.** Before bringing a civil legal action under the federal law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claims decision, in accord with this section. After the required reviews:
>
> 1. An ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
> 2. The Company will waive any right to assert that he or she failed to exhaust administrative remedies.

Haushild Decl., Ex. 1 at 25 and 47. Consistent with this two-appeal plan requirement, the November 3 denial letter told Noren how to obtain a second appeal. *See id.*, Ex. 11. Though Noren's response requested an extension of time in which to request an appeal, Noren never actually filed a second appeal.

This failure is fatal to Noren's ability to seek relief from this court. As the Ninth Circuit recently instructed:

> [B]ased on both the text of ERISA and its legislative history, we long ago concluded that 'federal courts have the authority to enforce the exhaustion requirement in suits under ERISA and that as a matter of sound policy they should usually do so.' *Amato v.* Bernard, 618 F.2d 559, 568 (9th Cir. 1980). Accordingly, we have consistently held that before bringing suit under § 502 [of ERISA], an ERISA plaintiff claiming a denial of benefits 'must available himself or herself of a plan's own internal review procedures before bringing suit in federal court.' *Diaz v. United Agric. Employee Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1483 (9th Cir. 1995).

Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008). Though not a jurisdictional requirement, this prudential exhaustion requirement "serves several important

policy considerations, including the reduction of frivolous litigation, the promotion of consistent treatment of claims, the nonadversarial method of claims settlement, the minimization of costs of claim settlements, and a proper reliance on administrative expertise." *Diaz*, 50 F.3d at 1483.

At oral argument, Noren's counsel agreed that the insurance plans include an explicit two-appeal process. Counsel contended that Noren completed this process, due to the indication in her response to the first appeal denial that she intended to file a second appeal within 180 days of receiving requested documents. But an indication of intent to file a second appeal is not the same as the filing of a second appeal. Counsel argued that Jefferson Pilot could have independently conducted a second appeal, but cited no authority obligating it to do so. Counsel's attempt to shift the burden to Jefferson Pilot to conduct claims appeals, in the absence of a request from a claimant, is unavailing.

Counsel also contended at oral argument that the denial letter from Jefferson Pilot did not explicitly inform Noren that failure to file a second appeal would prevent her from filing a civil action. But again, counsel has not cited any authority requiring that this information be included in a denial letter. The plan clearly states the two-appeal process, and Noren does not claim she did not have notice of that process.

Thus, because it is undisputed that the plans at issue required Noren to file two appeals before filing a civil action, and because she has not shown

that she did not seek two appeals or should be excused from doing so, the court concludes that Noren failed to exhaust the administrative remedies available under the plans at issue. Based on the prudential exhaustion requirement, the Defendants are entitled to judgment as a matter of law.

IV. CONCLUSION

For the foregoing reasons, the court GRANTS Defendants' motion (Dkt. #16).IT IS SO ORDERED.

DATED this 2nd day of March, 2009.

/s/ Richard A. Jones
The Honorable Richard A. Jones
United States District Judge

Title 29, United States Code, Section 1104(a)(1):

"Subject to sections 403(c) and (d), 4042, and 4044 [29 USCS §§ 1103(c), (d), 1342, 1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV".

Title 29, United States Code, Section 1133(1) – (2):

"In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits

under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2520.102-3:

Contents of summary plan description.

...**The summary plan description *must* accurately reflect the contents of the plans** ... The following information ***shall be included*** in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(j) The plan's requirements respecting eligibility for participation and for benefits.....

* * *

2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits....

* * *

(l) For both pension and welfare benefit plans, a statement clearly **identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset,**

> **reduction...of any benefits** that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. ... The foregoing summaries shall be disclosed in accordance with the requirements under 29 C.F.R. § 2520.102-2(b).

Title 29, Code of Federal Regulations, Section 2560-503-1(a):

"Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act".

Title 29, Code of Federal Regulations, Section 2560-503-1(b)(1-3), (b)(5):

"Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The

claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. ...

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants".

Title 29, Code of Federal Regulations, Section 2560-503-1(c)(2):

"Group health plans. (2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to

file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act"

Title 29, Code of Federal Regulations, Section 2560-503-1(f):

"Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim". ...

Title 29, Code of Federal Regulations, Section 2560-503-1(f)(3):

"Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the

circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information".

Title 29, Code of Federal Regulations, Section 2560-503-1 (g)(1)(iv)-(v)(a):

"Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant --

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(2)(iii)-(iv):

"Appeal of adverse benefit determinations.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other

information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination".

Title 29, Code of Federal Regulations, Section 2560-503-1 (h)(4):

"Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section".

Title 29, Code of Federal Regulations, Section 2560-503-1(i)(5):

"Timing of notification of benefit determination on review. ...

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate".

Title 29, Code of Federal Regulations, Section 2560-503-1(j)(2)-(3) and (5)(i):

"Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section"

(5) In the case of a group health plan or a plan providing disability benefits -- (i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request";

Title 29, Code of Federal Regulations, Section 2560-503-1(*l*):

"Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(4) – (5) and (8)(iv):

"Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or

service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information.

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination".

EXCERPT FROM JEFFERSON PILOT SUMMARY PLAN DESCRIPTION:

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Home Office of Jefferson Pilot Financial Insurance Company. To expedite the processing of your claim. instructions on the claim form should be followed carefully; be sure, all questions are answered fully. In accordance with ERISA, Jefferson Pilot Financial Insurance Company will send you a written notice of its claim decision within:

- 45 days after receiving the first proof of a claim for disability benefits (105 days under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You may request a review of the claim by making a written request to Jefferson Pilot Financial Insurance Company within:

- 180 days after receiving a denial notice of a claim for disability income benefits.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit tor consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. Jefferson Pilot Financial Insurance Company will make a full and fair review of the claim and provide a final written decision to

you within:

- 45 days after receiving the request for review of a claim for disability income benefits (90 days under special circumstances).

If more information is needed to resolve a claim, the information must be supplied within 45 days after requested. Any resulting delay will not count toward the above time limits for claims or appeals processing. Please refer to your certificate of insurance for more information about how to file a claim, how to appeal a denied claim, and for details regarding the claims procedures.

EXCERPT FROM JEFFERSON PILOT SHORT TERM WEEKLY DISABILITY POLICY:

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and

(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

EXCERPT FROM JEFFERSON PILOT LONG TERM DISABILITY POLICY:

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Employee may request a claim review by sending the Company:

1. a written request; and
2. any written comments or other items to support the claim.

The Insured Employee may review claim non-privileged information relating to the request for review.

The Company will review the claim and send the Insured Employee a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

1. any further appeal procedures available under this Policy;
2. the right to access relevant claim information; and
3. the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

1. an extension of up to 45 more days will be permitted; and

2. the Company will send the Insured Employee a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

1. the special circumstances which require the delay;
2. whether more information is needed to review the claim; and
3. when a decision can be expected.

Exception: The Company may need more information from the Insured Employee to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

1. an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
2. the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

EXCERPT FROM KRAFCHICK LAW FIRM LETTER TO JEFFERSON PILOT FINANCIAL DATED NOVEMBER 15, 2005:

... If you contend that this claim is governed by ERISA, please identify the plan administrator (name, address, phone number, fax number) and provide a copy of the Summary Plan Description or tell us the name, phone and fax numbers, and address of the person to contact to get the SPD. Also provide a copy of the insurance policy or policies applicable to our client's claim for disability benefits and a copy of Form 5500 filed with the Department of Labor.

In particular, if you believe this plan is governed by ERISA, we also request a copy of all documents, records, and other information relevant to our client's claim for benefits pursuant to 29 CFR 2560.503-1. This should include all documents, records or other information that was relied upon in making the benefit determination; that was submitted, considered, or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; that demonstrates compliance with required administrative processes or safeguards; or that constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for our client's diagnosis, whether or not it was relied on in making the benefit determination.

Furthermore it should include any internal rule, guideline, protocol, or other similar criterion applicable to handling of this claim.

Whether or not you contend this claim is governed by ERISA, we also request that you tell us the amount of the monthly short term and long term disability benefits our client will be entitled to if eligibility for benefits is established under the applicable policy or plan. Please let us know if there are any cost of living adjustments or other income deductions that you believe would apply.

Very truly yours,

/s/ Steven P. Krafchick
Steven P. Krafchick
Attorney

EXCERPT FROM JEFFERSON PILOT FINANCIAL LETTER DATED DECEMBER 12, 2005 TO KRAFCHICK LAW FIRM:

We are in receipt of your letter dated 11/15/05 regarding your client, Theresa Noren. Please direct all future correspondence to my attention as I will be handling Ms. Noren's appeal, when submitted, for Short Term disability benefits. The above claim number is correct and to date, your client has not been paid any benefits.

In response to your question regarding the decision made by the benefit specialist, it appears that she relied on the Presley Reid Medical Disability Advisor in making her decision. Please be assured that we will provide a full, fair and complete review of your client's claim on appeal, including a thorough review of her medical records.

Enclosed is a copy of Ms. Noren's Short Term disability claim file. I've also included a copy of the Short Term Disability policy issued to Ms. Noren's employer and the Summary Plan Description. The plan administrator and plan sponsor is Car Toys, Inc. The address is 20 West Galer, Seattle, WA 98119. The phone number is (206) 443-0980.

Please be advised that there were no other specific criteria utilized in assessing this claim. A determination of disability is based upon the terms of the contract and whether or not the medical records support the policy provisions for partial or total disability. Each claim is unique and is reviewed on its own merits. We rely on policy language and

ERISA regulations to ensure compliance in making our benefit determination.

...

Sincerely,

/s/ Lisa Koch
Lisa Koch
Disability Appeals Specialist

JEFFERSON PILOT FINANCIAL ADVERSE BENEFIT DECISION, LETTER DATED NOVEMBER 3, 2006:

We have completed our review of Ms. Noren's Short Term Disability appeal. Based on the information provided, we have determined that we are unable to approve benefits. In our appeal review process, all information previously submitted as well as any new documentation is used to make a determination.

To be eligible for benefits under the policy issued to Ms. Noren's employer, an individual must satisfy all of the provisions of the policy. This includes, but is not limited to, the following:

OWN OCCUPATION or REGULAR OCCUPATION means the occupation, trade or profession:
(1) in which the Insured Person was employed with the Employer prior to Disability; and
(2) which was his or her main source of earned income prior to Disability.

It means a collective description or related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

TOTAL DISABILITY or TOTAL DISABLED means the Insured Person's inability, due to Sickness or Injury, to perform each of the Main Duties of his or

her Own Occupation. A person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

According to the attending physician statement completed by Dr. Scott Pollack on 7/15/2005 Ms. Noren was unable to continue working as a wireless planner beyond 6/22/2005 due to fibromyalgia, migraines and cervical disc disease. As you know Ms. Noren's claim was denied short-term disability benefits on 7/27/2005.

Medical records we have received from Dr. Engel dated 3/28/2005 note the x-rays of her neck show multilevel degenerative disc disease to a moderate degree at C3-4, C4-5 and C5-6. No signs of spondylolisthesis or other abnormalities were noted. The physical exam showed full Shoulder motion, normal strength and mild tenderness at C3-6 and L4-S1. Dr. Engel's notes do not note any nerve involvement and he notes her neuromuscular and motor functions are intact to the hands as well as her feet. She was recommended conservative treatment of physical therapy and anti-inflammatory medication.

Records from Therapeutic Associates dated 4/19/2005 note Ms. Noren was taking part in physical therapy for cervical and thoracic pain. Ms. Noren notes that medication does relieve her symptoms. The last dated therapy note was dated 5/5/2005 and stated that, "The patient report feels

good that exercises are progressing slowly, not hurting after PT visit, except after last visit her shoulder was very irritated". The plan was to continue with therapy, however, we were not provided with these records.

Office notes dated 6/23/2005 from Dr. Scott Pollock note Ms. Noren increased her Mirapex on 6/19/2005 and became violently ill at work. Since that incident she discontinued the medication and had not suffered the side effects. Dr. Pollock noted on 6/28/2005 that you had an IBS flare and were unable to function at work or get out of bed. Ms. Noren was prescribed on 7/15/2005 Ms. Noren begin gentle aerobics.

It is understood that fibromyagia is generally a chronic syndrome, which has periods of waxing and waning the normal recovery period from a flare would be 3-7 days. The medical records support that while she was complaining of neck pain Ms. Noren was able to continue to work while receiving her conservative treatment of physical therapy and medication. The records show the claimant became ill due to an increase in her medication and the symptoms resolved.

In summary, the medical documentation does not support a condition that would render Ms. Noren unable to perform her occupation and does not support a total disability.

As a reminder, you have exhausted your first level of appeal. If you disagree with this decision you may pursue your second and final level of appeal to the

Jefferson Pilot Appeals Council. Please be sure to include, with your letter of appeal addressed to the Jefferson Pilot Appeals Council, all medical records from your attending or other physicians that you would like to have considered for review.

You or your authorized representative may request a review of your denied claim. Such request must be made in writing and submitted to us at the address below within 180 days after you receive this denial notice

Risk Services – Employee Care Center
Jefferson Pilot Financial Insurance Company
PO Box 2337
Omaha, NE 68114

Please include your reason(s) for appealing and provide any proof documentation, such as office notes, laboratory results, x-rays and any other testing results to support your appeal. We will then provide you with a full written explanation of the decision within 45 days of receipt of your appeal.

Please be sure to include your policy number and claim number. If you wish, you may also submit your comments and views of the issues in writing, and may request copies of the pertinent documents.

If your plan is subject to ERISA, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency. In addition, once all

required reviews of your claim have been completed; you have the right to bring a civil action under applicable law.

Please contact our office with any questions you may have at the number listed above.

Sincerely,

Kathryn Cave / JSR
Risk Technical Specialist

EXCERPT FROM KRAFCHICK LAW FIRM LETTER DATED NOVEMBER 6, 2006 TO KATHRYN CAVE OF "BENEFITS PARTNERS" RE: JEFFERSON PILOT PLAN BENEFITS DENIAL:

...In our initial letter of representation, dated November 15, 2005, we requested that you provide the documentation upon which you base your claim that the "usual and customary recovery period for your disability is 3-7 days for fibromyalgia and 1 day for a migraine headache." We noted that the statement you made in your July 27, 2005 letter regarding the usual and customary recovery periods for fibromyalgia and migraines came as somewhat of a surprise. We requested that you provide the internal policies and procedures, medical literature, medical opinions, evaluations, and all other information that you relied on for this highly questionable statement.

In response, Ms. Koch sent a letter dated December 12, 2005, stating tht the benefit specialist responsible for this bizarre statement "relied on the **Presley Reid Medical Disability Advisor** in making her decision." While Ms. Koch did provide us with the source of this questionable statement she failed to adequately address our request and provide the actual documents. We once again request that Jefferson Pilot immediately provide a copy of the **Presley Reid Medical Disability Advisor** and the internal policies, procedures, medical literature, medical opinions, evaluations, and all other information that apply to this claim.

...

Also, since you believe this plan is governed by ERISA, we also request a copy of all documents, records, and other information relevant to our client's claim for benefits pursuant to 29 CFR 2560.503-1. This should include all documents, records or other information that was relied upon in making the benefit determination; that was submitted, considered, or generated in the course of making the benefit determination without regard to whether such document, record, or other information was relied upon in making the benefit determination; that demonstrates compliance with required administrative processes or safeguards; or that constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for our client's diagnosis, whether or not it was relied on in making the benefit determination. Furthermore, it should include any internal rule,l guideline, protocol, or other similar criterion applicable to handling of this claim.

Whether or not you contend this claim is governed by ERISA, we also request that you tell us the amount of the monthly benefit our client will be entitled to if eligibility for benefits is established under the applicable policy or plan. ...

We hereby request that you provide us with one hundred eighty (180) days from our receipt of the requested complete administrative record to submit additional information in support of our client's claim. If we do not hear from you to the contrary within fourteen (14) days we will consider that as an agreement to this extension request.

Very truly yours,

/s/ Steven P. Krafchick
Steven P. Krafchick
Attorney

APPEAL WORKSHEET

APPEAL WORKSHEET*

Claimant's Name: Teresa Noren

Initial Claim Info

1st Appeal Info

1st Appeal received: 5/30/06
Review to be done by: LAK

2nd Level Appeal / Appeal Counsel
2nd Appeal received ~~11/6/06~~ [THE DATE IS HANDWRITTEN AND CROSSED OUT]

Review to be done by: MYB

* The appeal worksheet is a form. The entries are handwritten. We have provided what is legible.